COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Webinar and Teleconference

Supporting the Health Care Workforce during the COVID-19 Pandemic

April 29, 2020
12:00 p.m. – 5:00 p.m. ET

Council Members in Attendance
Erin Fraher, PhD, MPP, Chair
Thomas C. Tsai, MD, MPH, Vice Chair
Andrew Bazemore, MD, MPH
Ted Epperly, MD
R. Armour Forse, MD. PhD, FRCS(C), FACS, FCCM, FASMBS
Beulette Y. Hooks, MD, FAAFP
John J. Norcini, PhD
Ashruta Patel, DO, MS
Karen Sanders, MD
Leith J. States, MD, MPH
Kenneth Veit, DO, MBA, FAOFP

Health Resources and Services Administration Staff Present:
Kennita Carter, MD, Designated Federal Official, COGME
Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Kimberly Huffman, Director, Advisory Council Operations, HRSA
Janet Robinson, Advisory Council Operations, HRSA
Zuleika Bouzeid, Division of Extramural Affairs, HRSA

Welcome and Roll Call

Kennita R. Carter, MD, Designated Federal Official, COGME

Dr. Kennita Carter, Designated Federal Official (DFO) for the Council on Graduate Medical Education (COGME, or the Council) convened the meeting at 12 noon, on Wednesday, April 29, 2020. The meeting was a webinar and teleconference, sponsored by the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Rockville, MD 20857. Dr. Carter conducted an initial roll call, and a quorum was not present. Dr. Carter proceeded with the initial agenda items. Other members of the Council soon joined the call, establishing the required quorum for the full meeting to proceed.

At Dr. Carter's request, the Council observed a brief moment of silence in gratitude for the healthcare workforce and staff on the frontlines in hospitals, clinics, and other settings caring for patients during the challenging times of the COVID-19 pandemic.

Dr. Carter turned the meeting over to Dr. Erin Fraher, COGME chair. Dr. Fraher welcomed the three new members of the Council: Dr. R. Armour Forse, Dr. Beulette Hooks, and Dr. Ashruta Patel. Dr. Fraher moved to the first agenda item.

Bureau of Health Workforce Update

Luis Padilla, MD, Associate Administrator, Bureau of Health Workforce, HRSA

Dr. Fraher introduced Dr. Luis Padilla, Associate Administrator, Bureau of Health Workforce (BHW), HRSA. Dr. Padilla thanked the Council members for dedicating their time and expertise to help advise the federal government on its pandemic response, particularly on efforts to better prepare and protect the workforce while also looking to the post-pandemic recovery phase. Dr. Padilla discussed the steps taken by the Department of Health and Human Services (HHS) and HRSA to help lead the ongoing pandemic response. He noted the critical role that HRSA plays in improving health care accessibility for people who are geographically isolated and economically and medically vulnerable, listing several key accomplishments:

- HRSA awarded $165 million to support nearly 1,800 small and rural hospitals and provide additional funding to 14 telehealth research centers.

- HRSA awarded more than $1.3 billion to nearly 1,400 health centers across the country to help communities prepare for COVID-19 detection, prevention, diagnosis, and treatment, while maintaining capacity and staffing levels.

- HRSA would soon release another $600 million to assist health centers in advancing their COVID-19 testing capabilities at the community level.

- HRSA also awarded $90 million to support 581 Ryan White AIDS programs, including city and county health departments, health clinics, community-based organizations, and state health departments, as well as AIDS education and training centers, in their efforts to minimize the impact of the pandemic on people living with HIV and AIDS.

Dr. Padilla highlighted several federal sources of information on ways to prevent and control the spread of infection, including COVID-19 safety training from the National Institutes of Health (NIH), and COVID tracking and public health information regularly released by the Centers for Disease Control and Prevention (CDC).

Dr. Padilla added that BHW is focusing its COVID-19 response in three main areas:

- Program flexibilities – helping National Health Service Corps and Nurse Corps participants meet service obligation and compliance requirements in the face of rapidly changing conditions within health systems.

- Grant flexibilities – BHW's project officers are working hard to identify our grantees' current activities, capabilities, and unmet needs

- Telehealth – HRSA funding and technical support is helping clinical sites transition from in-person visits and clinical training to telehealth and tele-education formats.

Dr. Padilla identified a major pivot for HRSA, and for BHW in particular, in looking to the future of telehealth to deliver services, as well as tele-education to train future health professionals. He indicated the desire of BHW to increase the capacity to offer virtual trainings

and simulations and prepare future health workforce to provide telehealth services. BHW is also working with stakeholders to identify ways to increase its outreach and promote awareness of its training and funding opportunities.

There was a question from the Council about funding free clinics with volunteer staff. Dr. Padilla replied that the recently passed CARES Act provided $100 billion in funding targeted towards hospitals and providers across the country, with a portion of those funds dedicated to those who are providing care to uninsured patients and communities.

Dr. Fraher asked about HRSA support for telemedicine in both clinical practice and training, and its potential use in team-based care involving members from different healthcare disciplines. Dr. Padilla noted that several HRSA grantees have received funding for telemedicine initiatives, while HRSA had a significant focus on interprofessional training. HRSA is always looking for best practices, and before the COVID pandemic many grantees had developed exemplar models of interprofessional training. However, clinical training in interprofessional team-based care has not been a significant component of current programs. He added that HRSA would continue to provide support for different models or training and attempt to identify best practices.

Meeting Overview

COGME Chair Dr. Erin Fraher provided an overview of the day's agenda. She stated the goal was for the Council to develop three to five direct and actionable recommendations that the HHS Secretary and Congress could use to support the health workforce during the ongoing COVID-19 pandemic. She described this work as imperative, given that the number of cases in the United States had recently passed one million. Dr. Fraher added that the pandemic was having a disproportionate impact on vulnerable populations, including rural populations and individuals from underrepresented minority groups.

Dr. Fraher noted that, given its broad charge, COGME was uniquely positioned to consider recommendations on a range of measures that could be directed towards policymakers, educational institutions, regulatory and licensure bodies, accreditation bodies, as well as federal agencies both within and outside of HHS, such as the Department of Education. The meeting would include three panel discussions with invited speakers with a wide range of backgrounds and expertise. The panels would focus on the impact of COVID-19 on the health care workforce in three distinct areas:

- Sustaining the current workforce
- Training and accelerating the entering workforce
- Preparing and integrating the returning workforce

Dr. Fraher shared a conceptual framework of the pandemic developed by Dr. Tom Tsang, from the Division of Pulmonary, Allergy, Critical Care Medicine, and Sleep Medicine at Emory University. Over time, the impact of the pandemic would be felt in four waves:

- The immediate mortality and morbidity of COVID-19 – those patients who are currently hospitalized, and the workforce needed to care for them.

- Individuals who have delayed seeking care for urgent, non-COVID conditions, for fear of exposure to infection.

- Individuals with chronic conditions who have seen their routine care interrupted, which may result in worsening health and a need for hospitalization.

- The huge psychological trauma, mental health concerns, burnout, and economic injury for the health workforce dealing with the emergent and long-term COVID response.

COGME Vice Chair Dr. Thomas Tsai added that two COGME workgroups had drafted an initial set of recommendations, which would be reviewed and revised with input from the panel discussions. One major theme of these recommendations centered around the importance of bolstering the telehealth infrastructure, which covers both sustaining the existing workforce as well as training and accelerating the entering workforce. Increased use of video and telephone visits may help in reaching underserved communities and providing care to those reluctant to have in-person visits during the time of the pandemic. The workgroups identified temporary waivers and reimbursement changes from the Centers for Medicare and Medicaid Services (CMS) relating to telehealth visits that could be extended or made permanent.

A second theme related to stabilizing vulnerable practices, including support through reimbursement changes as well as funds from the stimulus package. COGME had recognized a need to provide financial relief to primary care practices, critical access hospitals, and other health facilities struggling with the changing landscape brought by the pandemic.

Other ideas included strengthening and modernizing the public health and preventive medicine workforce, including an emphasis on preventive medicine residencies and ways to augment public health training in other specialties and disciplines. The groups also discussed the potential impact of COVID-19 on healthcare workforce stress, fatigue, and burnout, and the need to provide behavioral care, mental health services, and other direct support to healthcare workers.

Public Comment Session #1

Dr. Carter opened the lines for public comment.

The first respondent was Dr. Edward Dudley-Robey, with veteransfirst.org. Dr. Dudley-Robey raised the issue of unmatched physicians – recent medical graduates who did not receive a match into a residency program. He noted that several thousand U.S. citizens and green card holders did not match into residency positions in 2020, although they have graduated from medical school and passed their initial board exams. Many in this group stand ready and willing to help, and many are volunteering in health systems across the country. He expressed concern that the knowledge and expertise of these individuals could be wasted in this time of crisis, while public health service would be one potential avenue for employment. He asked the Council to consider ways to use these unmatched graduates, before exploring options like pulling current students out of medical schools early or recruiting physicians from other countries, where they may be

needed more.

The next respondent was Hope Wittenberg, from the Society of Teachers of Family Medicine. Ms. Wittenberg commented on the use of programs under Title VII of the Public Health Act to help with workforce retraining. She noted the plasticity exhibited by many providers, such as family physicians transitioning to acute care to help relieve overburdened hospital staff. However, she expressed concerns on the topic of graduate medical education (GME) cap flexibility. Any expansion, redistribution, or flexibility in the GME caps should take into account the needs of underserved areas and the distribution of medical specialties. Underserved areas can occur even within urban regions, while large rural areas often lack access to many medical specialties. Any revision or redistribution of residency slots should be directed to rural or other underserved areas that have a greater need the spots and the training.

Panel Discussions: Supporting the Health Care Workforce during the COVID-19 Pandemic

Dr. Fraher proceeded to the panel sessions, stating that she and Dr. Tsai would serve as moderators, and asking Council members to reserve their questions until the end of each session.

Panel Discussion #1: Sustaining the Existing Workforce

Dr. Fraher said that the first panel would address issues and recommendations related to sustaining the existing workforce. She introduced the panelists:

- John S. Andrews, MD (Vice President, Graduate Medical Education Innovations, American Medical Association)
- Cheryl A. Peterson, MSN, RN (Vice President for Nursing Programs, American Nurses Association)
- Reamer Bushardt, PharmD, PA-C (Senior Associate Dean, The George Washington University School of Medicine and Health Sciences)
- Lauren Block, MPA (Program Director, Center for Best Practices' Health Division, National Governors Association)

John S. Andrews, MD (Vice President, Graduate Medical Education Innovations, American Medical Association)

Dr. Andrews, Vice President, Graduate Medical Education Innovations, American Medical Association (AMA), expressed the support of the AMA for small business loans and other avenues of financial assistance to help physician practices that are struggling in the pandemic response due to decreased patient volume.

In terms of accelerating workforce entry for new physicians, Dr. Andrews noted that many schools of medicine have chosen to graduate their classes early. Some graduates have been able assist in the COVID-19 response or actually enter their medical residency programs early. For telehealth, new or relaxed regulations allow teaching physicians to provide services with residents and students virtually through real-time audio and video communications technology.

AMA supports this practice and is working to seek appropriate reimbursements for those services. Furthermore, alternate reimbursable locations for residents have been approved as long as they meet physician supervision requirements, improving workforce availability.

However, students in clinical situations are in a vulnerable position, and the AMA has issued two recent documents:

- Guiding principles to protect learners responding to COVID-19
- Guiding principles to protect resident & fellow physicians responding to COVID-19

Through engagement with other physician groups, the AMA agreed with the loosening of visa restrictions to allow international medical graduates (IMGs) to travel to areas of need, or to engage in telemedicine. The AMA also supports efforts to temporarily allow retired physicians who have given up their licenses to come out of retirement and practice, as well as to allow physicians to cross state lines to practice where they are needed most. However, he noted several issues related to licensing and to malpractice coverage.

Dr. Andrews referenced two bills currently before Congress:

- Rural America Health Corps Act, to address workforce shortages in rural communities.
- Health Heroes 2020 Act, which includes a provision that expands the National Health Service Corps and establishes a Reserve Corps to maintain surge capacity in response to public health emergencies.

Dr. Andrews added that Congress had passed a stimulus package containing several policies relevant to GME, including deferral of student loan payments, the use of supplementary educational opportunity grants for emergency aid, and continuation of Federal work study payments, as well as Child Care and Development Block Grant funds to provide childcare assistance to healthcare sector employees. A further stimulus package was under debate, and the AMA advocated for continued relief of student loan and tuition burdens for medical students and residents responding to COVID-19, and cap flexibility in CMS GME reimbursement to hospitals to accommodate variations in training due to the COVID-19 response.

Cheryl A. Peterson, MSN, RN (Vice President for Nursing Programs, American Nurses Association)

The next speaker, Ms. Peterson, Vice President for Nursing Programs, American Nurses Association (ANA), described ANA as the largest professional association for registered nurses (RNs) in the United States, with a mission to build a healthy world through the power of nursing.

Ms. Peterson said that a recent ANA survey with over 13,000 RN respondents found that over three quarters felt concern over safety due to a lack of personal protective equipment (PPE). This concern was shared across all care venues, not just in acute care units where RNs were providing direct care to COVID-19 patients. Respondents also expressed concern about working with insufficient staff. Most urgent areas identified for professional education were: proper use of PPE, care of COVD-19 patients, and maintaining personal and patient safety. Lack of

sufficient access to PPE supplies has directly impacted the nurses related to their trust both in their workplace and in the governmental and regulatory institutions providing guidance.

In terms of recommendations for the Council to consider, Ms. Peterson said the seminal narrative around the pandemic has been PPE, and keeping healthcare providers and staff safe. Given the breach of trust that many nurses feel, there is a risk of many leaving the profession, as well as a risk of losing prospective students. She urged COGME to address this basic issue.

Ms. Peterson said that ANA supports leveraging all members of the interprofessional team to their fullest extent. Policies and protocols have changed to a certain extent during this pandemic, to improve team-based care, and these need to be extended.

The ANA also identified a real immediate need for education, both formal and informal. RNs cannot simply move from one clinical unit to another and be expected to function safely and effectively, they need education and training. In addition, retired nurses coming back to the field to help during the pandemic response need adequate retraining. Ms. Peterson said that the ANA is looking to address some of the educational needs for nurses, sharing that over 88,000 nurses viewed a recent webinar on infection control and PPE. The ANA has also prepared material on care of the ventilated patient with acute respiratory distress to help nurses who might be moving into an unfamiliar area to understand the type of care needed. Ms. Peterson added that the ANA is also working to address the mental health, well-being and moral distress experienced by nurses, which is expected to have a long-term impact on the nursing workforce.

She said that the ANA has also heard concerns about the allocation of scarce resources such as ventilators for patient care. RNs want to make sure that these decisions involve input of the entire healthcare team and are made in a transparent and equitable manner.

For the future, the ANA is planning new educational materials on the clinical picture of the COVID-19 patient and implications for nursing care, health disparities and inequities related to the pandemic, and the well-being and recovery of healthcare workers and providers. Recommendations that she asked the Council to consider related to the recovery phase included:

- Engage in an assessment of policy changes to determine effectiveness.
- Conduct an extensive interprofessional After Action Review to identify lessons learned and inform future responses.
- Engage in interprofessional disaster preparedness training and education.

Ms. Peterson indicated that the after-action review and analysis of the pandemic response should begin now, and inform what changes to health care should be retained, and what may need to be adjusted and changed during an emergency response. She acknowledged the expansion of telehealth, with nurses engaged in triaging COVID patients, helping get concerned individuals to the correct sites for testing, and giving them information about how to get treatment or to care for themselves or family members at home. Both RNs and advanced practice registered nurses (APRNs) need to have the flexibility to respond appropriately to assist in patient care. The most important outcome will be to assess how to translate the lessons learned about professionals

working together during the pandemic into day-to-day patient care and build the trust needed for interprofessional teamwork.

Reamer Bushardt, PharmD, PA-C (Senior Associate Dean, The George Washington University School of Medicine and Health Sciences)

Dr. Bushardt introduced himself as a physician assistant (PA) and a pharmacist at the George Washington University (GWU) School of Medicine & Health Sciences. He said his primary goal in his presentation was to capture some of the voices from interviews he held with:

- Frontline providers, including physicians, residents, PAs, and nurse practitioners, who are treating patients diagnosed with COVID.
- Providers in outpatient and inpatient settings whose jobs have been negatively impacted by the disruption on routine and non-emergent care from COVID
- Leaders within GWU GME program coordinating the pandemic response.

Dr. Bushardt identified three themes that emerged from these interviews. The first pertained to regulatory and practice barriers that limit the current workforce from practicing at the top of their license, and being nimble in response to staffing needs. He said PAs and nurse practitioners (NPs) had been furloughed due to reductions in nonemergent care, while several large health systems in the Washington, D.C., region were asking for help to support clinical staffing during the COVID surge, or oversee mobile testing and assessment clinics. In this area, he recommended that COGME:

1. Advocate for suspension/elimination of regulatory barriers at state and federal levels and clarify waivers that limit top-of-license practice.
2. Work to develop registries of healthcare providers and allow providers to perform additional services to alleviate strain on health care delivery systems.
3. Create guidance to accelerate new employee screening and onboarding in crisis situations.

The second theme concerned protecting and supporting the frontline workforce, including the provision of PPE, along with developing best practices on how to reduce transmission and improve education and training. Recommendations under this theme included:

1. Require health systems to train their staff and assess provider readiness for a pandemic response, and maintain adequate supplies of PPE.
2. Fund training in emergency/operational medicine for healthcare providers to support leadership during the pandemic response and to enhance interprofessional collaborative practice.
3. Increase access to diagnostic testing for COVID-19.

Dr. Bushardt stated that the final theme was focused on mental health and emotional well-being of our frontline workers. He noted that he had encountered feelings of guilt anxiety, fatigue, high-stress work conditions, and emotional distress expressed by team members who were on the frontlines. Meanwhile, providers not on the frontline felt under-utilized and unsure how to help. Recommendations in this area included:

1. Facilitate safe environments for providers to openly discuss concerns/challenges and formulate strategies.

2. Develop evidence-based criteria and ethics-informed practices around acute care resource management during a crisis.

3. Expand access to mental health and counseling services to frontline providers.

Lauren Block, MPA (Program Director, Center for Best Practices' Health Division, National Governors Association)

Ms. Lauren Block introduced herself as the lead of the health workforce portfolio in the National Governors Association (NGA) Center for Best Practices. In the quickly-evolving landscape of the pandemic response, this Center has worked to help states share best practices. She noted that CMS has granted many temporary flexibilities to states in Medicare and Medicaid programs related to providers. However, significant authority resides within the state governments to address health workforce issues via legislative action, executive orders, and proclamations.

Ms. Block said that healthcare providers have to maintain a license in each state in which they render services to patients. However, states can allow for reciprocity, temporary waivers, or expedited licenses so that providers can practice across state lines. In addition, many states participate in interstate compacts to simplify the licensure process when providers move between states covered under the compact.

Similarly, state legislators have been addressing telehealth in terms of providing health coverage and provider participation. Some states have also chosen to participate in the emergency medical assistance compact, which is a multi-disciplinary and mutual aid compact, and has been used for workforce and some telehealth flexibilities. She emphasized that liability protections are a critical element to licensure and telehealth.

Ms. Block added that many states have taken action to help maintain and increase the number of providers by granting flexibilities to in-state licensure requirements, such as by suspending regulatory provisions related to lapsed licenses, extending deadlines for continuing education, accelerating licensure for recent graduates, and expanding credentialing. Another strategy that states have taken to expand the pool of clinical health workers relates to scope of practice, such as by authorizing temporary extensions for APRNs practice at the top of their license and bill for reimbursable services. Another example has been to allow emergency medical service workers the option not to transport certain patients to the hospital whose symptoms can be managed at home or outside of an emergency setting. States have also taken action to support parents by identifying strategies for childcare for essential workers, particularly in the health sector.

In addition, she said, many states have been mobilizing students training in a health discipline, to

keep this pipeline of the future workers on track and to see where they can support the workforce while granting some flexibility to training institutions and accreditation bodies. Finally, there are strategies to credential veterans who hold military medical certification, and leveraging the skills of foreign-trained health providers who are not licensed in the United States by temporarily waiving or modifying requirements.

Ms. Block informed the Council that the NGA, along with the Association for State and Territorial Health Officials, recently published a road map for a phased reopening of economic activity, to protect the public health while laying a strong foundation for economic recovery. In April, the governors wrote a letter to Congress requesting support from the federal government as states and localities navigate their response to the pandemic, along with transparency in the distribution and access to PPE and other medical supplies, as healthcare workers on the front line need to be appropriately protected.

Panel 1: Q&A
Dr. Fraher opened the floor to questions from the Council members.

Dr. Andrew Bazemore pointed to lessons might be learned from studying the responses to the pandemic from different countries around the world. As one example, he cited New Zealand, which has had success in critical responses such as identifying, tracking, and tracing cases of COVID infection through strong connection between public health and primary care. Dr. Bazemore highlighted efforts made at many medical schools. One early response to the pandemic was to remove medical students from clinical rotations. As a result, medical schools have scrambled to create curricula for students that satisfy accreditation requirements while allowing them to remain engaged. Many schools have developed electives or rotations in public health, allowing students to work with state and local governments to manage case identification and tracking. However, primary care residencies are struggling to create clinical environments where their trainees can continue to be engaged with the volume of patients that supports their training, as many outpatient clinics are experiencing sharp declines in patient volumes.

Ms. Block agreed that contact tracing is a focus area for many states. Fundamental to contact tracing is having access to testing capacity and the availability of PPE for those conducting the testing. There are some estimates indicating that 100,000 contact tracers will be necessary. She stated that she has led work surrounding data collection and reporting, including the appropriate demographic information to help make tracing easier for public health agencies, identify hot spots, and conduct appropriate outreach and follow-up.

Dr. Ted Epperly stated that telehealth had rapidly become fundamental to the provision of health care in the pandemic environment, and will need to continue beyond the time of the pandemic. He asked about the NGA position on policies to make current temporary changes to telehealth regulations, such as reimbursement parity with in-person visits, more permanent. Ms. Block noted that there are certain requirements at the federal level through CMS. However, states retain significant authority for telehealth coverage and payment parity, while there is variability across states. She agreed that state governors and legislators will be giving a lot of consideration to telehealth changing, including opportunities for states to evaluate the temporary flexibilities that have been granted and to consider permanent policies changes.

Panel Discussion #2: Training and Accelerating the Entering Workforce

Dr. Tsai moderated the second panel discussion, focused on the needs of graduating students entering the healthcare workforce. He introduced the panelists:

- Atul Grover, MD, PhD (Executive Vice President, Association of American Medical Colleges)
- Eric Holmboe, MD (Chief Research, Milestone Development, and Evaluation Officer, Accreditation Council for Graduate Medical Education
- Robert A. Cain, DO (President and CEO, American Association of Colleges of Osteopathic Medicine)
- William Pinsky, MD (President and CEO, Educational Commission for Foreign Medical Graduates)

Dr. Atul Grover, Executive Vice President, Association of American Medical Colleges

Dr. Grover, Executive Vice President, Association of American Medical Colleges (AAMC), said that AAMC represents the medical schools, teaching hospitals, and health systems that do about 20 percent to 25 percent of all the clinical care in the country, as well as over half of the biomedical research funded by NIH. Dr. Grover described the impact of the pandemic on medical education in terms of the interruption and cancellation of clinical rotations, altered curricula, and changes in competency assessment. AAMC has issued guidance for those students participating in direct care, and has been tracking the innovative adjustments made by medical educators and the volunteerism of medical students. He noted that some schools developed online curricula for public health, pandemic, and epidemiologic training in lieu of suspending some in-person clinical rotations.

Dr. Grover commented that AAMC has projected a shortage of physicians that will expand in the coming years. The pandemic response has resulted in a re-evaluation of the specialty mix of the workforce in terms of both physicians and other health professionals. However, COVID has exposed the need for hospital-based physicians, as well as the need for more slack in the system to allow hospitals to adjust to rapidly changing conditions. In particular, AAMC is monitoring workforce exits, as many older physicians are entering or contemplating retirement.

In regard to the work of COGME, Dr. Grover said that AAMC continues to support team-based health care, to promote the use of health professionals to the extent of their training and licensure, including NPs, RNs, and PAs, as well as therapists, pharmacists, and social workers. About three quarters of health professionals train at academic medical centers. He reminded the Council that Medicare pays for about 21 percent of the costs of residency training, while teaching hospitals and health systems absorb the majority of those costs. In moving forward, the AAMC has recommended:

- Supporting the provider relief fund, and improving the advanced and accelerated payment programs.

- Clarifying that teaching hospitals should not be penalized for addressing surge capacity.

- Funding research on the workforce to figure out what worked well and what did not during the pandemic.

- Supporting providers through PPE, Good Samaritan protections, and other steps.

He said that legislative changes intent on expanding the workforce could allow medical schools to train another three or four thousand doctors per year. He added that HRSA grant programs continue to target specialties for underserved areas through programs such as the Children's Hospital GME, the Health Careers Opportunity Program (HCOP), Centers of Excellence, and Area Health Education Centers. Diversity needs to remain a priority for these programs, in light of the devastating impact of the pandemic on minority and vulnerable populations.

Dr. Eric Holmboe, Chief Research, Milestone Development, and Evaluation Officer, Accreditation Council on Graduate Medical Education

Dr. Eric Holmboe thanked COGME for the opportunity to provide an update on the Accreditation Council for Graduate Medical Education (ACGME). He said that early in the pandemic response, ACGME created pandemic status levels, in order to grant affected institutions some relief from accreditation program requirements provided that they met key principles on the provision of PPE, duty hours, and the wellness of their staff. ACGME also developed a COVID-19 resource page that has been regularly updated. ACGME also instituted a well-being group as part of an initiative of the National Academy of Medicine.

Dr. Holmboe shared some statistics showing the disproportionate impact of the pandemic on minority and other vulnerable populations in many regions across the country, signaling serious problems within the health system that are being borne out by the pandemic.

Dr. Holmboe noted the growing importance of telehealth. In response, ACGME accelerated a new telehealth common program requirement designed to help enable supervision of learner-directed telehealth visits. The ACGME internal medicine group had already written a telehealth milestone competency that will be helpful moving forward. Telehealth will become a major part of healthcare practice, and thus will need to become a component of training. Finally, ACGME has started conversations about the future of inter-professional telehealth.

With regard to integrating those entering the workforce, Dr. Holmboe said that ACGME was able to accelerate the adoption of the core components of a competency-based medical education approach along with other steps to better prepare medical students in the transition to residency, and residents in the transition to fellowship programs or clinical practice.

Lastly, Dr. Holmboe said that ACGME is examining ways to assess and assist retired physicians and others looking to re-enter the workforce to contribute to the pandemic response. Identifying a need for more efficient mid-career training. ACGME is set to launch a project to allow practicing physicians to receive training in hospice and palliative care through distance learning and within their current workplace. A similar program is being discussed for geriatric medicine. ACGME is also exploring other models for individuals looking to renter the workforce and wishing to stay within their specialties.

Robert Cain, DO, President and Chief Executive Officer, American Association of Colleges of

Osteopathic Medicine

The next panelist was Dr. Robert Cain, President and Chief Executive Officer (CEO), American Association of Colleges of Osteopathic Medicine (AACOM). Dr. Cain identified AACOM as the association representing the thirty-seven colleges of osteopathic medicine in the United States. He added that approximately one quarter of all medical students currently in training are earning the doctor of osteopathy (DO) degree, with 7,000 new osteopathic physicians graduating this year. He noted that approximately 20 percent of osteopathic medical schools are located in federally designated rural and underserved areas, and much of the clinical training for DO students has occurred in these areas, intending to create and enhance relationships with community health settings.

Dr. Cain described the AACOM plan during the COVID-19 crisis, addressing four main areas of concern; integrating technology into medical education, developing clinical education alternatives, maintaining and improving pathways into and out of medical school, and contributing to the health of the public by determining how medical students can meaningfully participate in the COVID-19 response.

Dr. Cain said that AACOM convened workgroups to identify problems related to the needs of medical students. This included continuing meaningful education in the disrupted environment, determining safe roles to contribute to the crisis response, addressing unmet healthcare needs particularly in community settings and related to mental health, and developing an organized system-level response, both for use in the current response and as a model for future local, regional, and national crises.

One outcome was the creation of Students Assist America (SAA), an interprofessional effort to mobilize the future healthcare workforce by combining education with service. Dr. Cain described the goals of SAA as: to outline meaningful roles for medical students while allowing them to continue their medical education, to convey these roles to health system leaders and public officials, and to replicate and scale the response by working with other healthcare professionals. For example, students can participate in contact tracing as a real-life, interprofessional educational activity. The enhanced education and experience related to public health, community health, and mental health should continue into GME residency programs, particularly those focused on primary care, psychiatry, general surgery, emergency medicine, and obstetrics. Greater emphasis on prevention and public health must be a part of all GME residency training in the future.

According to Dr. Cain, AACOM recommended that medical students and other students be initially placed in roles with minimal risk that were more commensurate with their education, with the purpose to fill gaps created as more highly trained professionals moved into higher-risk clinical areas. With time, training, and PPE availability, some students may migrate into the higher-risk zones in limited roles. The intent was to promote students as a valued part of the healthcare workforce. AACOM has communicated that the involvement of students must be safe, supervised, and appropriate to their level of training.

Dr. Cain summarized by stating that AACOM is adapting in this time of crisis to make sure that the medical students who constitute the future physician workforce continue their education so

that they are prepared to enter GME, contribute to the pandemic response, and strengthen the response by involving other healthcare professionals within a plan of team-based care.

William Pinsky, MD, President and CEO, Educational Commission for Foreign Medical Graduates

The final panelist of the second session was Dr. William Pinsky, President and CEO, Educational Commission for Foreign Medical Graduates (ECFMG) and Chair, Foundation for Advancement of International Medical Education and Research (FAIMER). Dr. Pinsky stated that ECFMG was founded over seventy years ago to conduct primary source verification and certification for physicians who have gone to medical school outside of the United States and Canada and wish to come to the United States as IMGs for further training. ECFMG verifies that every IMG seeking entry into the United States attended a medical school that meets basic requirements, have passed the U.S. medical board exams, and is eligible for entry into the country. He said that ECFMG sponsors incoming IMGs through the J-1 Visa program. ECFMG is the only agency that the U.S. Department of State authorizes to sponsor physicians on the J-1 visa, which is a cultural exchange visa, not an immigration visa. He added that ECFMG is responsible for the health and welfare of these IMGs while they are in the United States.

Dr. Pinsky shared the results for IMGs in the 2020 residency match process, which had over 12,000 IMG applicants, with just over 60 percent receiving a match. He noted that over half of the first-year interns for internal medicine residencies were IMGs, with many of the training programs located in underserved communities. After the match process concluded in March 2020, ECFMG contacted the Department of State to assure that IMGs who matched would be able to enter the United States to fulfill their obligation. A recent study found that 69 percent of IMGs serve in rural and other underserved areas. Dr. Pinsky outlined some temporary changes to the J-1 visa process due to the pandemic and resultant travel restrictions.

Dr. Pinsky said that ECFMG has been working with training programs to anticipate the needs of the IMGs as they arrive in this country, and recently concluded a survey on resources for quarantine, housing, and related concerns. ECFMG has also been working with local ethnic groups that represent the IMGs to provide local support within the communities where they are training and practicing. ECFMG is also working with an organization called “Airlines for America”, that represents the US airline industry, and they are working with ECFMG to see how they can coordinate travel for international medical graduates. In all of these steps, ECFMG has worked in partnership with the AMA and AAMC.

Panel 2: Q&A

Dr. Tsai opened the floor to questions from the Council members. Dr. Epperly said that one potential silver lining of the COVID-19 pandemic was to serve as a catalyst for much-needed change, such as the acceleration of telehealth and its incorporation as a new common program requirement in the education and training of physician residents. He expressed concern, however, about the identified gaps in the national workforce related to geriatrics, palliative care, and end-of-life care. He asked Dr. Holmboe how ACGME might facilitate the training and transfer of mid-career physicians into these fields, and how COGME might help. Dr. Holmboe replied that ACGME has seen interest from mid-career physicians to move into these fields,

which could serve to rebalance the workforce in areas of need. Many programs are targeting more rural areas or community-based clinics to meet local needs and make use of distance learning and other techniques. He suggested that COGME could recommend funding in this area and revised training policies, as physicians changing fields cannot enter a full-time fellowship.

Dr. Norcini asked Dr. Pinsky about the potential role that unmatched medical school graduates, both graduates of schools in the United States and IMGs, might play in the current pandemic response. Dr. Pinsky stated that ECFMG has reached out to many groups, including governors offices around the country. However, ECFMG is not a licensing body, and individual states will have to determine licensing requirements for practice. He noted that traditional residency programs facilitate the transition of medical school graduates into independent practitioners. However, the unmatched graduates may be able to assist licensed physicians, or provide manpower for COVID testing programs and other public health initiatives. Dr. Grover added that in the long term, there may be a need to expand the number of training programs to ease the problem of unmatched graduates. In the short-term, though, unmatched graduates may be able to participate in contact tracing, telemedicine, and triage.

Panel Discussion #3: Preparing and Integrating the Returning Workforce
Dr. Fraher introduced the panelists for the third session, to address preparations needed for healthcare professionals looking to return to the workforce in response to the pandemic:

- Maryann Alexander, PhD, RN (Chief Officer, Nursing Regulation, National Council of State Boards of Nursing)
- Humayun J. Chaudry, DO (President and CEO, Federation of State Medical Boards)

Maryann Alexander, PhD, RN, Chief Officer, Nursing Regulation, National Council of State Boards of Nursing

Dr. Maryann Alexander, Chief Officer, Nursing Regulation, National Council of State Boards of Nursing (NCSBN), stated that the NCSBN is composed of fifty-nine boards of nursing for the states and territories of the United States, and its mission is to empower these boards in their efforts to promote safe and competent nursing practice.

Dr. Alexander reviewed the pre-pandemic healthcare environment, in which there was a lack of access to care, especially in the rural and disadvantaged population, resulting in significant health disparities. There were barriers to APRNs providing care to the full extent of their training, and barriers to the mobility of the nursing workforce. Dr. Alexander said that the NCSBN has worked with the state nursing boards to make access to care and problems associated with mobility and licensing barriers one of the top priorities. In the years before the pandemic, NCSBN had instituted an interstate compact to allow a nurse to have a license issued by the primary state of residence that permits the nurse to practice, either physically or electronically through telehealth, in other states within the compact without requiring an additional license. For APRNs, before the pandemic, twenty-three states allowed full practice authority, and other state nurse practice acts included practice restrictions.

However, as the pandemic reached the United States in early 2020, lack of access to care and health disparities contributed to poor health outcomes. In response, the entire nursing workforce has needed to practice to the full extent of their ability. Because of the compact, many RNs and

APRNs were able to move across state borders to assist where they were needed most. In particular, there was a rapid rise in the demand for certified registered nurse anesthetists to assist with ventilator management for COVID patients. As discussed previously, CMS issued waivers early in the pandemic response to relieve some of the barriers placed on APRNs, enabling them to practice to their full scope of their education and licensure, such as being allowed to order tests, medications, and durable medical goods.

Dr. Alexander said that one recommendation for the post-pandemic phase is to permanently remove these practice restrictions. There is also a push to adopt the nurse licensure compact nationwide, as well as to adopt the compact for advanced practice registered nurses. She noted that data more than support removing these regulatory barriers to increase access to care.

For retired nurses or those with inactive licenses looking to return to the workforce, NCSBN recommended granting temporary licenses or expedited reactivation to help increase the workforce and take advantage of the knowledge and experience of returning nurses. However, care will be needed to train the returning workforce for safe practice. In addition, many retired nurses desiring to return to work may be in a high-risk category due to their age or other health conditions for acquiring COVID-19 or suffering more serious outcomes.

Humayun Chaudhry, DO, MS, MACP, President and CEO, Federation of State Medical Boards

Dr. Humayun Chaudhry, President and CEO, Federation of State Medical Boards (FSMB), described FSMB as the umbrella organization for all seventy-one of the state and territorial medical boards in the United States. Its primary purpose is to protect the public through licensing and regulation. FSMB supports the state boards through education, assessment, and advocacy. FSMB also administers the medical licensing board exams and collects data on the results. Dr. Chaudhry added that FSMB has a great deal of information about the nation's physician and PA workforce, and it conducts a census every two years. For example, in 2018 there were over 985,000 actively licensed physicians, the majority of them were MDs and had graduated from a U.S. or Canadian medical school, while 23 percent were IMGs.

In response to COVID-19, Dr. Chaudhry said that FSMB quickly mobilized data and advocacy resources to assist the states and territories, and provided free access to its physician data center, a comprehensive licensure database of every single licensed physician and physician assistant in the nation. FSMB also created a pandemic response taskforce and developed a web site to share COVD-related information. In addition, FSMB provided recommendations for licensure portability during the pandemic.

Dr. Chaudhry said state medical boards have shown extraordinary flexibility by temporarily waiving or modifying medical licensure requirements to meet healthcare workforce needs for out-of-state healthcare professionals, and for the provision of telehealth across state lines, and expedited licensure for retired or inactive physicians. He noted that, similar to the nursing compact discussed previously, twenty-nine states and two territories take part in an Interstate Medical Licensure Compact. In addition, eleven states allowed early MD and DO graduates to provide care under the supervision of a licensed physician before July 1, when they would ordinarily start their residencies.

Dr. Chaudhry noted that in New York State, 100,000 volunteers answered that call of the governor for health care workers. FSMB worked with New York and other states and territories to rapidly verify the credentials of doctors and PAs. He stated that at a time a natural disaster or an emergency, individuals may show up with good intentions, but they may not be qualified doctors or nurses, so the availability of a database that has those types of credentials is crucial.

He said that in March 2020, FSMB issued an Interprofessional Consensus Statement, along with leading organizations from nursing, pharmacy, psychology, physical therapy, occupational therapy, and social work, which declared a commitment to public health, public protection, and patient safety by exploring ways to support qualified healthcare professionals as they respond to the evolving national emergency. FSMB is also part of the Coalition for Physician Accountability, which issued a consensus statement in support of strengthening efforts to safeguard the public, while also protecting our nation's healthcare workforce during the pandemic.

Dr. Chaudry emphasized the value of accurate and current data. States and territories, as well as hospitals and health centers where licensed physicians and PAs are employed, need to be able to rapidly verify the qualifications and credentials of healthcare providers. It may be necessary to move toward electronic verification of credentials. States and territories value their primary mission to support safe practice as much as they value the health and safety of their healthcare workers. He added that the call within the CARES Act for a U.S. Public Health Service Ready Reserve Corps could be timely in developing an adequately trained workforce specific to public health epidemiology.

Panel #3: Q&A

Dr. Fraher opened the floor to questions from the Council members.

Dr. Tsai asked if the use of the emergency waivers for both physicians and nurses during the pandemic might create momentum to make the changes permanent. Dr. Alexander replied that there is evidence of the benefit of removing many of the licensing restrictions and of expanding the license compacts nationwide. Dr. Chaudhry said that the practice of medicine would change after the pandemic has passed. The temporary changes and increased use of technology have the promise of expanding access to care and increasing the capacity to deliver care. He noted that the current focus is on the immediate response, but hoped there would be an openness to evidence-based changes to the practice of medicine in the future.

Dr. Kenneth Veit stated that a few states had created a license category for MDs who did not match into a residency. These "junior physicians" could add to the workforce, particularly in underserved areas, but would need supervision. Dr. Chaudhry agreed that FSMB was aware of this special licensure category as a temporary response. However, there were many potential issues with providing the necessary supervision, so it was unclear if this type of licensure could be a permanent solution in providing a path for unmatched medical graduates.

Dr. Tsai asked about the process of rapid mid-career redeployment within nursing, and ways to help facilitate the training, licensing, or other support when there was an emergent or rapid need to deploy nurses from their usual roles. Dr. Alexander noted that RNs have a general license,

giving them the ability to shift between specialty areas. She said that on-line courses have been used to help provide nurses with the training and competencies to assist in these transitions.

Dr. Epperly noted a large gap nationally around the workforce for geriatrics, hospice, and palliative care, and asked APRNs might be able to move into these specialties mid-career. Dr. Alexander replied that she had recently received a statement from an organization of geriatric adult nurse practitioners asking NCSBN to sign on to support having adult nurse practitioners take a geriatric rotation in their advanced practice nursing programs. So, nursing recognizes the interest and need to support workforce development in those areas.

Public Comment

Dr. Carter opened the telephone lines for public comment. Dr. Karen Mitchell, from the American Academy of Family Physicians, emphasized the need for physicians in rural areas, which often lack large academic health systems. She stated that the most flexible approach for rural areas is to promote generalist training such as family physicians and general surgeons. She noted the growing need to promote GME training slots in rural areas, because most physicians practice near the area where they trained, as well as the need to develop telehealth services.

Dr. Alok Amraotkar, from the University of Louisville, stated that he is a U.S. citizen who finished his medical education abroad. He noted that over 4,400 U.S. citizen medical school graduates, classified as international medical graduates because they attended school outside of the country, did not match for a residency this year. He asked that consideration be given to employing unmatched graduates as mid-level providers, working under the supervision of a licensed physician, as they pursue their careers to become lifetime health care providers.

Council Discussion

Dr. Fraher moved to the next agenda item, a discussion of the COGME recommendations. She said that workgroups within the Council had drafted an initial set of recommendations related to the COVID-19 pandemic and the physician and healthcare workforce. During the discussion, the Council should consider each recommendation with the following questions in mind:

- Are there any issues, concerns about, or objections to the recommendation?
- Is there any additional content to include in the recommendation?
- What information from the panelists could be incorporated into the recommendation?

Dr. Fraher turned the meeting over to Dr. Tsai to go through the recommendations one by one. Dr. Tsai reminded the Council that the first recommendation centered around bolstering the telehealth infrastructure, with specific points related to:

- driving access to telehealth through public and private partnerships,
- identifying temporary waivers for reimbursement that could be made permanent,

- providing reimbursement parity for telephone versus video telehealth visits,

- investing in community-based telehealth transformation through flexibility of grant programs and the removal of regulatory barriers.

Dr. Epperly commented that the remarks of many of the panelists supported and reinforced the Council's recommendation on telehealth, along with the importance of the interstate licensing compacts, to mobilize a national workforce during an emergency. He added that there could also be the opportunity to address some long-term national health workforce gaps. Dr. Fraher noted that the pandemic has brought to the forefront the need to strengthen and modernize public health and preventive medicine. There was further comment that recommendations from COGME typically address issues at the federal level, but state governments often are dealing with commercial health insurers to encourage reimbursement for telehealth visits.

Dr. Tsai moved on to discuss Recommendation 2, which calls for stabilizing and providing financial relief to rural practices and critical access hospitals. He noted that several panelists had discussed the CARES Act and the various stimulus packages to support practices that are struggling from decreased patient volumes for routine or non-emergent care during the pandemic. Dr. Fraher urged the Council members to consider not just the declines in routine care visits, but the needs of patients with long-term, chronic illnesses. Dr. Forse referred to one framework of the pandemic response showing several waves, including the wave of patients who have delayed care. He noted that the workforce has struggled through the first wave, but will soon have to turn more attention to other longer-term health impacts and a potential influx of patients in a compromised state due to healthcare delays.

Dr. Andrew Bazemore brought up the potential acceleration of a trend in which small or independent practices in rural and urban underserved populations are prone to financial stresses. COGME can make recommendations for a future workforce to serve vulnerable populations, but the country will suffer a major step backwards if there is a shutdown of the existing workforce serving vulnerable populations. Dr. Epperly stated that there will be a pent-up demand for care, and most patients will not be seen in hospitals. The closure of struggling community-based practices and clinics would intensify the already glaring issue of disparities in access to care.

Dr. Tsai transitioned the discussion to Recommendation 3, on streamlining the visa approval process for international medical graduates. Dr. John Norcini said that this recommendation was a lower priority for the immediate pandemic response than the first recommendations discussed, but was still important for the long-term planning of the healthcare system. He also believed the recommendation could be expanded to cover unmatched medical graduates. Dr. Veit added that medical graduates represent a very well-educated and well-prepared component of the health workforce. When graduates are unable to obtain a residency match or other employment, then the time and money invested in their education and training is wasted. He said that the number of unmatched graduates points to a need for more residency slots. However, these slots should not be allocated in the typical manner focused on urban-based academic medical centers, but rather could move into ambulatory care and other venues.

Dr. Tsai moved to the next recommendation on CMS residency cap flexibility. He noted that increasing residency slots and making the residency caps more flexible had the potential to

address both the short-term needs of the pandemic response, and the longer-term needs of addressing workforce gaps. Dr. Norcini proposed making the recommendation explicit in terms of addressing new residency slots to areas of need. Dr. Epperly agreed that an across-the-board increase would result in "more of the same," while failing to address the areas of greatest need. Dr. Fraher said that she noted two central themes: lifting the residency caps needs to be tied to addressing areas of need; and residencies need to be kept broad to improve the flexibility of the workforce, particularly in addressing a public health emergency.

Dr. Tsai moved to the next recommendation on addressing workforce fatigue, stress, and burnout as a result of the pressures of the pandemic response. Dr. Forse commented about the framework of the different waves of the pandemic. He said he had heard many stories about the stresses front-line healthcare workers are experiencing with the first wave, involving the direct response to the disease. Meanwhile, the issues of stress and burnout are likely to recur with each wave, and expand to include primary care and other areas of health care. He expressed concern that the topic had not received much discussion or direction. Dr. Tsai pointed out that supporting the workforce was a component of the previous recommendations.

Dr. Epperly proposed some strategies to address stress and burnout. First, a recommendation to promote the concept of interdisciplinary teams by involving NPs and PAs, as well as social workers, community health workers, and others. This model of team-based care could serve to reduce stress among any one segment of the care team. Second, leveraging technology could help teams work together and better address population health. Third, payment models must support team-based care within communities, working proactively to keep people healthy. He suggested that these steps together could help in decreasing stress and burnout.

Dr, Fraher agreed with the need to be cognizant of the behavioral and mental health needs of providers. She noted the risks pointed out during the panel discussion of current workers dropping out of the workforce, or others not entering or choosing different careers, worsening current provider shortages and access to care. Dr. Bazemore added the need for COGME to call out that the COVID-19 pandemic had exacerbated long-standing concerns of stress and burnout within the healthcare workforce. Dr. Beulette Hooks agreed with the importance of the problem, but noted that many rural areas and even military hospitals lack sufficient mental health providers to help everyone in need. Dr. Fraher pointed to the recommendations for investment in the mental health workforce, to address the areas of greatest need.

Dr. Tsai raised the last recommendation, regarding workforce flexibility and interstate licensing compacts for both physicians and nursing. Dr. Norcini noted the importance of creating a national repository or database, similar to the discussion in the panel session, but to include a broader range of healthcare professionals. There was further discussion related to liability issues of practice across state lines, and of lapsed or retired workers returning to the workforce.

COGME recommendations

Based on the preparatory work of the Council in advance of the meeting, the panel presentations, and the subsequent Council discussions, COGME proposed a set of direct and actionable recommendations to present in a letter to the HHS Secretary and Congress covering the following five high-priority areas:

- Bolster Telehealth Accessibility, Usage, and Infrastructure
- Stabilize/Provide Financial Relief for Vulnerable Practices and Critical Access Hospitals
- Strengthen and Modernize the Public Health Workforce
- Sustain and Increase CMS Cap Flexibility for New and Existing Residency Programs in Specialties and Geographic Areas of Need
- Address Workforce Stress, Fatigue, and Burnout

Business Meeting

Discussion: HCOP Letter to the Secretary

The Council reviewed a draft letter to the Secretary of Health and Human Services on the Health Careers Opportunity Program (HCOP), to contain the following recommendation: "The Council believes not only that HCOP needs to remain funded, but that the funding for fiscal year FY 2020 should be increased by 25 percent over the FY2019 appropriation of $14.2 million, to a level of roughly $18 million." In discussion, the Council members reached consensus on using the additional funds to support recruitment health care workers from the local community, or "grow-your-own" programs. The Council also agreed to add language recommending flexibility with the use of the funds to respond to the COVID-19 pandemic, given the disproportionate impact on rural communities and minority populations.

Meeting Adjourn

Dr. Fraher thanked the members of the public for their comments and their engagement in this meeting, underscoring the importance of the Council's work. She thanked the panelists for sharing the expertise, and the Council members for their work in the previous weeks to draft the initial recommendations, helping to make the meeting a success. She also thanked the HRSA staff for their support of the Council.

Dr. Carter adjourned the meeting at 5:00 p.m.

Acronym and Abbreviation List

AACOM	American Association of Colleges of Osteopathic Medicine
AAMC	Association of American Medical Colleges
ACGME	Accreditation Council for Graduate Medical Education
AMA	American Medical Association
ANA	American Nurses Association
APRN	Advanced Practice Registered Nurse
BHW	Bureau of Health Workforce
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CMS	Center for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
DFO	Designated Federal Official
DO	Doctor of Osteopathy
ECFMG	Educational Commission for Foreign Medical Graduates
FAIMER	Foundation for Advancement of International Medical Education and Research
FSMB	Federation of State Medical Boards
GME	Graduate Medical Education
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IMG	International Medical Graduates
NCSBN	National Council of State Boards of Nursing
NGA	National Governors Association

NIH	National Institutes of Health
NP	Nurse Practitioner
PA	Physician Assistant
PPE	Personal Protective Equipment
RN	Registered Nurse
SAA	Students Assist America